ADVISORY COMMITTEE ON MANAGED HEALTH CARE

ANNUAL REPORT

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EXECUTIVE SUMMARY

The Advisory Committee on Managed Health Care has worked during the past year to assist the Department of Managed Health Care ("the Department") in its effort to act as a control tower over the HMO industry, working to ensure a more solvent and stable system that is responsive to the needs of consumers.

This first report to the Director highlights our recommendations to the people at the Department about ways we think they can best continue their efforts for a better managed health care system.

A USEFUL, USABLE HMO REPORT CARD FOR CONSUMERS

The Department and the Office of the Patient Advocate released its first-ever report card on California HMOs' quality of care and service on September 24, 2001.

We recommend that the Department and the Office of the Patient Advocate use the second annual report card to expand the scope of the first report card to:

- Continue to find ways to ensure consumer friendliness and ease of use;
- Work toward inclusion of Medi-Cal, Healthy Families, Medicare and provider group performance measures;
- Use report card results to identify potential enforcement issues; and,
- Include, in addition to HMO Help Center complaint data, Independent Medical Review data.

BRING HMOS BACK TO THEIR ROOTS: MAKE PREVENTIVE HEALTH A PRIORITY

Advisory Committee members have heard a great deal of testimony about the benefits of aggressive preventive health care, both in terms of better quality of life as well as potential cost savings in the health care system.

The Advisory Committee will report to the Director on the state of preventive health in California HMOs as well as steps the Director could take toward improving this critically important area of health care.

EXPLORE HOW BETTER ONLINE TECHNOLOGY COULD PROVIDE BETTER HMO HEALTH CARE

Using the Internet to provide basic health care services, such as online medical records, appointment scheduling and personalized health care reminders, has enormous potential for improving health care in HMOs and providing a quantum leap in convenience of services. There are also great challenges,

such as protecting medical privacy and ensuring access by all consumers. We recommend that the Department explore ways and take steps to help improve the state of e-Health in California, without interfering or micro-managing the industry.

IMPROVE HMO INTERNAL COMPLAINT OFFICES

The launch of the Department's HMO Help Center and its wide range of consumer assistance services demonstrate the need for the HMOs to improve their own internal complaint processes. The Department's pending grievance and Independent Medical Review regulations are designed to ensure that HMOs resolve complaints quickly and effectively, based on the best information from consumers and their physicians. We also recommend they work to ensure a strong line of communication between the HMO Help Center and the individual HMO complaint offices.

HELP PROTECT MORE HEALTH CARE CONSUMERS

Under the current system in California, the Department of Managed Health Care regulates HMOs, and Preferred Provider Organizations (PPOs), for the most part, are regulated by the California Department of Insurance. This can be very confusing for consumers, especially those seeking assistance through our Help Center or through the California Department of Insurance.

We recommend that the Department work with the California Department of Insurance to ensure greater clarity for consumers on which agency to call and a positive experience for any HMO or PPO consumer who calls either Department.

We further recommend that the Department conduct an exploration of additional issues relating to California's regulatory framework, including current unregulated entities such as provider groups.

REDUCE DUPLICATION IN AUDITS

Provider groups and physicians currently undergo multiple quality audits by HMOs. Without sacrificing the quality, we recommend that the Department work to find ways of reducing duplicative auditing and unnecessary paperwork. The reduction of unnecessary administrative work will free HMOs and other health care providers to devote more time to patient care.

Annual Report of the Advisory Committee on Managed Health Care

Introduction

In accordance with the requirements of the Knox-Keene Health Care Service Plan Act (the "Knox-Keene Act"),[1] the October 2001 Report of the Advisory Committee on Managed Health Care ("Advisory Committee") contains the following:

- The Advisory Committee's recommendations to the Director on producing a report card to the public on the comparative performance of the managed care organizations overseen by "the Department"; and,

- The Advisory Committee's top five recommendations for improving the health care delivery system and quality of care.

In making these recommendations, the Advisory Committee is drawing upon the recommendations, views and suggestions by health care delivery system stakeholders, including health plans, providers, consumers, regulators, and individuals and organizations dedicated to quality improvement. These were obtained at a series of meetings of the Advisory Committee and its three subcommittees: the Quality and Performance Measurement Subcommittee, the Regulatory Implementation and Structure Subcommittee, and the Health Care Education and Access Subcommittee (see Appendix 1).

[1] Section 1347(c), added by Assembly Bill 78 (Chapter 525, Statutes of 1999), describes the purpose and responsibilities of the Advisory Committee on Managed Health Care as follows: "The purpose of the committee is to assist and advise the director in the implementation of the director's duties under this chapter and to make recommendations that it deems beneficial and appropriate as to how the department may best serve the people of the state. The committee shall produce an Internet-accessible annual public report that will, at a minimum, contain recommendations made to the director. At a minimum, the report shall include the following:

(1) Recommendations to the director on producing a report card to the public on the comparative performance of the managed care organizations overseen by the department, including health care service plans and subcontracting providers, building on the work of the private sector and other government entities and including complaint information received by the state.

(2)(A) The committee's top five recommendations for improving the health care delivery system and quality of care taking into consideration information received from the public.

(B) To assist the committee in formulating its recommendations, the views and suggestions of the public should be solicited. The committee shall accompany the director at least twice each year for public hearings (with at least one in northern California and at least one in southern California).

(C) This report shall be delivered to the director, the Governor, and to the appropriate policy committees of the Legislature."

Recommendations for the Report Card on Comparative Health Plan Performance

The Quality and Performance Measurement Subcommittee was charged with the responsibility to develop recommendations for a report card of comparative health plan performance and to bring these recommendations to the full Advisory Committee. Due to the need for the Department to issue the Year 1 Report Card no later than the fall of 2001, the Quality and Performance Measurement Subcommittee's formal recommendations below were for the Year 2 Report Card.

I. Recommendations for the Year 1 Report Card

Initial meetings of the Advisory Committee and the Quality and Performance Measurement Subcommittee included discussions with state and national experts about report cards. These discussions greatly helped the Department and the Office of the Patient Advocate develop its strategy for the Year 1 Report Card.

The Department announced on March 20, 2001 that it had awarded a contract to the Pacific Business Group on Health to assist in developing a report card on California health plans for the Year 1 Report Card. At the Advisory Committee's April 11, 2001 meeting, representatives from the Pacific Business Group on Health presented and participated in a discussion about the scope of the Year 1 Report Card. The Year 1 Report Card ultimately included quality information on 17 Health Maintenance Organizations in California representing 14 Knox-Keene licensees, which together cover approximately 95 percent of California's commercial enrollment.

Advisory Committee members recommended that, in addition to English and Spanish, the Year 1 Report Card be available in at least one Asian language. Based upon this recommendation, the Department and the Office of the Patient Advocate printed a version of the Year 1 Report Card in Chinese. Advisory Committee members also stated their interest in having future report cards expanded to include reporting for the Medi-Cal population.

II. Recommendations for the Year 2 Report Card

The Quality and Performance Measurement Subcommittee's recommendations for the Year 2 Report Card were presented to, and adopted by, the full Advisory Committee at its April 11, 2001 meeting. These recommendations, outlined below, were based upon panel presentations to the Quality and Performance Measurement Subcommittee, and comments by public participants and Subcommittee members, at the December 7, 2000 and January 30, 2001 Subcommittee meetings (see Appendix 2).

Identifying Key Audiences and Purpose of the Year 2 Report Card

- **Consumers Are a Key Audience for the Report Card.**

  A key audience for the report card is consumers and a key purpose of the Report Card should be to assist consumers in health plan choice.

  The Subcommittee noted the following additional considerations:

  - ✓ The report must be understandable by consumers.
  - ✓ There is a need to educate consumers in the use of Report Cards.
  - ✓ Efforts should be made to assure the availability of quality information at the time consumers need to make a health plan choice.
  - ✓ Service and access indicators are important in their own right, and should be included in the Report Card.

- **Commercial and Medicare Populations Are Separate Audiences and Reporting for Both Audiences Should Be Included in the Report Card.**

  The Report Card should include reporting for commercial and Medicare populations separately. Both commercial and Medicare populations are target audiences, and the Department should take CalPERS' lead in including reporting for both commercial and Medicare populations.

  The Subcommittee noted the following additional considerations:

  - ✓ It is important to take into consideration findings regarding Medicare members' ability to use information.
  - ✓ It may be appropriate to get input from the Centers for Medicare and Medicaid Services ("CMS") regarding what is most important for Medicare members.

- **Medi-Cal Enrollees Are a Separate Audience and Reporting for Medi-Cal Should Be Included in the Report Card.**

  The Report Card should cover Medi-Cal members and distinguish between results for Medi-Cal and non-Medi-Cal members as separate populations to compare performance.

  The Subcommittee noted the following additional considerations:

  - ✓ The Report Card published on Department's website should include a link to the Department of Health Services' web site.
  - ✓ The Department and the Office of the Patient Advocate should coordinate with the Department of Health Services to assure that the Report Card addresses any potential additional concerns of the Department of Health Services.

- **Consumers Are a Regional Audience.**

  The Report Card should report findings by region so that the most relevant information is available for consumers.

  The Subcommittee noted the following additional considerations:

  - ✓ Regions should be defined to assure consistency in reporting. Defining the regions is something that will need development.
  - ✓ Regions should be small enough so that results are meaningful to consumers.
  - ✓ Some overall plan information, for example, overall complaint data, may be included in a regional Report Card where it is not feasible to separate data by region.

- **Purchasers Are a Key Audience.**

  Purchasers who decide what health plans to offer at what price are a key audience for the Report Card.

  The Subcommittee noted the following additional considerations:

  - ✓ The Department/Office of the Patient Advocate should do outreach so that benefit managers throughout the community are aware of the Report Card and can make Report Card information available to employees at the time of health plan choice and open enrollment.

- **Regulators Should Monitor Report Card Results.**

  Even though regulators are not the primary audience for the Report Card, the Department/Office of the Patient Advocate should monitor Report Card results so that appropriate regulatory activities will be triggered when the Report Card identifies poor plan performance.

  The Subcommittee noted the following additional considerations:

  - ✓ There must be a mandate for regulators to look for linkages for poor performance. However, the Report Card should not be designed towards regulatory enforcement, as the Report Card would end up being very detailed and not very useful to consumers.
  - ✓ Low Report Card scores should trigger further regulatory activity such as medical surveys or financial examinations of plans to pinpoint the sources of plan problems.
  - ✓ An unacceptable level of plan performance may need to be defined by thresholds or benchmarks.
  - ✓ Knox-Keene licensed full-service plans should be required to participate in gathering information; results should be public. Otherwise, plans may choose to opt out of the Report Card process.

- **Providers Are a Key Audience for a Report Card that Includes Hospital and/or Provider Group Ratings.**

  Consumers benefit when provider group ratings cause medical groups to improve performance. Consumers also benefit when physicians direct patients to hospitals with good performance. However, it is not clear whether the inclusion of provider information is feasible for a Year 2 Report Card.

Selecting a Framework for Reporting and Choosing Performance Measures for Inclusion - Year 2 Report Card

- **The Subcommittee Agreed Upon Recommendations Concerning Basic Criteria for a Year 2 Report Card:**

  - ✓ The Year 2 Report Card should be based on credible, independent and validated information.
  - ✓ The Year 2 Report Card should use standardized information.
  - ✓ The Year 2 Report Card should build on existing tools. However, recognizing there are complicated information sets, some measures may be included in Year 3 and beyond.
  - ✓ A small number of good measures that are of value to the target audience for the Year 2 Report Card should be chosen.

- **The Subcommittee Cannot Make a Recommendation about Inclusion of Provider Group Information in the Year 2 Report Card.**

  The Subcommittee does not have sufficient information to make a recommendation that the Year 2 Report Card should include provider group information.

  The Subcommittee noted the following additional considerations:

  - ✓ The Subcommittee is in favor of reporting as much provider information as soon as it is feasible to do so, but the feasibility of including provider information in a Year 2 Report Card is not clear. However, the Subcommittee recommends moving as quickly as possible to include provider information in the Report Card.

- **Accreditation Information May Be Useful to Include in a Report Card, but the Subcommittee Cannot Make a Recommendation About Inclusion of Accreditation Information At This Time.**

  The Subcommittee recommends that accreditation information, in general, may be useful to include in a Report Card. However, the Subcommittee recommends revisiting the question of inclusion of accreditation information at a later time.

The Subcommittee noted the following additional considerations:

- ✓ The Subcommittee cannot make a recommendation regarding inclusion of accreditation information by any specific organization.
- ✓ The Subcommittee's recommendation should not constitute a mandate for organizations to seek National Committee for Quality Assurance ("NCQA") accreditation.

- **The Year 2 Report Card Should Not Include Information at the Hospital Level.**

  The Year 2 Report Card should not include information at the hospital level, but inclusion of hospital information should be considered for Year 3.

  The Subcommittee noted the following additional considerations:

  - ✓ Morbidity and mortality information that lack consideration of illness severity is misleading.

- **HMO Help Center Complaint and Independent Medical Review ("IMR") Data Should be Included in the Report Card.**

  HMO Help Center Complaint and IMR data should be included in the Report Card subject to validation and relevance to consumers.

  The Subcommittee noted the following additional considerations:

  - ✓ The Subcommittee has made this recommendation given the assurance by Department staff that confidentiality is not an issue since only aggregate data, which is a matter of public record, will be used.

- **The Year 2 Report Card Should Include Additional Comparative Information to the Extent Feasible.**

  The Year 2 Report Card should include any of the following comparative information, to the extent feasible:

  - ✓ Credentialing information
  - ✓ Financial information such as market share and medical loss ratios
  - ✓ Provider turnover rates
  - ✓ Assessment of enrollees' linguistic needs
  - ✓ Department medical survey information
  - ✓ Enforcement actions against plans
  - ✓ Arbitration results
  - ✓ Health benefit design/plan features

  The Subcommittee noted the following additional considerations:

- ✓ The decision to include the above-described information in a Report Card is not an all or none decision. Inclusion of any of the above information should be based on feasibility.

- **The Year 2 Report Card Need Not Include Lengthy General Information.**

  Information to assist enrollees on how to use their health plan is already included in the information available on the Department's website. The Report Card can link to other sites or publications for background information to assist enrollees in how to use their health plan.

Recommendations for Improving the Health Care Delivery System and Quality of Care

The Advisory Committee's top five recommendations to the Director for improving the health care delivery system and quality of care are as follows:

I. The Director Should Implement a Preventive Care Initiative For Health Plans to Focus on Prevention.

II. The Director Should Adopt Regulations for a Uniform Medical Quality Audit System to Reduce Duplicative Health Plan Audits of Medical Groups and Redirect Resources to Meaningful Quality Improvement.

III. The Director Should Explore e-Health Strategies to Promote Patient Access and Quality Improvement.

IV. The Director Should Assure that Health Plans Provide Enrollees with Fair and Timely Complaint Resolution Procedures Including the Opportunity to Appeal Denials of Health Care Services.

V. The Director Should Consider a Broad Range of Options to Ensure Consistent Consumer Protections for Persons With Health Care Coverage.

I. The Director Should Implement a Preventive Care Initiative for Health Plans to Focus on Prevention.

The Advisory Committee shall produce a document that explains the current state of preventive health care in California and provide recommendations for how to make improvements. The document will focus on how better prevention could save lives and health care resources, what HMOs are currently providing in the way of preventive health and what more they can and should do to help managed care return to its founding premise of better preventive health. This document should include recommendations to the Director on what should be done to improve preventive health care in California's HMOs.

Background

Leading experts nationally and within California have presented information about health care prevention to the Health Care Education and Access Subcommittee of the Advisory Committee. Representatives from the Center for Health Improvement[2] have presented information to the Health Care Education and Access Subcommittee, documenting deficiencies with the provision of preventive services in California and nationally, as evidenced by the following findings:

- In a survey of California adults who received healthcare services through a managed care plan, 68 percent of smokers reported that they had received no help to quit smoking from their healthcare provider or plan.[3]

- There had been a drop in the following types of health promotion programs offered by California HMOs from 1995 to 1998: substance abuse prevention (-30%), sexually transmitted disease, prevention (-26%), childhood injury prevention (-25%), HIV/AIDS prevention (-19%), and prenatal nutrition (-14%).[4]

- Only five percent of members reported participating in a health improvement program through their health plan.[5]

- Medi-Cal managed care spent more per member per year on preventive services than their commercial HMO counterparts, $4.66 vs. $1.89.[6]

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[2] The Center for Health Improvement is a Sacramento-based prevention-focused health policy center committed to improving the health of the public by disseminating information about community health and healthcare issues.

[3] From California Center for Health Improvement Fact Sheet, *The State of Prevention in California*, referencing the California Managed Health Care Improvement Task Force Survey of Public Perceptions and Experiences with Health Insurance Coverage, UC Berkeley and Field Research Corporation, September 2 - 24, 1997.

[4] From California Center for Health Improvement Fact Sheet, *The State of Prevention in California,* referencing HH Schauffler and ER Brown. *The State of Health Insurance in California, 1999,* Berkeley, CA: Regents of the University of California, 2000, and Sara McMenamin's presentation at the February 6, 2001 Health Care Education and Access Subcommittee meeting referencing this source.

[5] Sara McMenamin's presentation at the February 6, 2001 Health Care Education and Access Subcommittee meeting.

[6] From Center for Health Improvement Fact Sheet, *The State of Prevention in California*, referencing HH Schauffler and ER Brown, *The State of Health Insurance in California, 1998.* Berkeley, CA: Regents of the University of California, 1999.

Nationally, services that provide good value, but are now delivered at low rates, include the following: tobacco cessation, adolescent counseling services, screening for vision impairment among older adults, Chlamydia screening among young women, screening for colorectal cancer among persons over 50, screening for problem drinking among adults and providing brief counseling, and vaccinating adults over age 65 for pneumococcal disease (see Appendix 3).[7]

Discussion

The Health Care Education and Access Subcommittee will develop a Prevention Report for presentation to the Advisory Committee and the Director, which shall include the following:

- A summary of recommendations for preventive health care, such as the frequency of health assessments, screenings, vaccinations and behavioral counseling.[8]
- A summary of the state of preventive health in the United States and in California, and how the health care system and demographics of California affect preventive health efforts.
- A summary of the benefits of different types of preventive health measures, their effectiveness, and their cost and potential savings.
- A description of the state of preventive health in California HMOs today, including the extent of coverage of, and co-payments for preventive services in California HMOs, the best programs offered by California HMOs, and where there are gaps in preventive services and why.
- An analysis of the barriers to delivery of effective preventive services in California HMOs.
- Recommendations to the Director on how to improve provision of preventive health care in California HMOs, which may include recommendations for regulations to promote provision of preventive health services.[9]

[7] At the March 23, 2001 meeting of the Health Care Education and Access Subcommittee, Ashley Coffield, M.P.A., President, Partnership for Prevention described how clinical preventive services can be prioritized according to their effectiveness and cost in order to assist decision-makers in determining priorities for preventive care initiatives. She described a study that used two components to rank services: Clinical Preventable Burden, which measures the burden of disease a service can prevent, and Cost Effectiveness. This list will be published in the American Journal of Preventive Medicine in July 2001.

[8] Recommendations shall be consistent with the *Guide to Clinical Preventive Services, Second Edition*, Report of the U.S. Preventive Services Task Force.

[9] Recommendations to the Director shall be consistent with the *Guide to Community Preventive Services* for those topics where information has been released. The *Community Guide* uses systematic reviews to evaluate the evidence of intervention effectiveness, and the Task Force on Community Preventive Services makes recommendations based on the findings of these reviews.

Timeframe

The Health Care Education and Access Subcommittee anticipates bringing the draft Prevention Report to the full Advisory Committee in late 2001 or early 2002, finalizing it upon review and comment by all Advisory Committee members.

II. The Director Should Adopt Regulations for a Uniform Medical Quality Audit System to Reduce Duplicative Health Plan Audits of Medical Groups and Redirect Resources to Meaningful Quality Improvement.

Under the Knox-Keene Act, health plans must oversee the quality and accessibility of care delivered to health plan enrollees, and must satisfy federal and state laws for participation in the Medicare and Medi-Cal programs. Increasingly, health plans must also meet requirements by private accreditation organizations to satisfy employers. Health plans primarily deliver medical services through contracted arrangements with medical groups and, since medical groups often contract with multiple health plans, medical groups and providers are subject to multiple and frequently duplicative health plan audits. By adopting regulations that define standards for a uniform medical quality audit system, the Department can contribute to reducing the administrative and financial burden on providers, while ensuring that resources are redirected to meaningful quality improvement.

Background

Assembly Bill 1959 (Chapter 658, Statutes of 1998) required the Department of Corporations[10] to convene a working group to develop standards for quality audits with the goal of reducing duplicative audits of providers of health plans. The Section 1380.1 Working Group formed in response to this legislation published a December 1999 report, *Reducing Duplicative Provider Audits: A Strategic Blue Print for Action*, which, among other recommendations, proposed baseline core health quality standards for provider groups and individual physicians. The Section 1380.1 Working Group recommended that once a provider or provider group was audited, and found to meet these standards, the provider would be exempt from multiple audits for regulatory compliance. Based upon the Working Group's December 1999 report, SB 2136 (Chapter 856, Statutes of 2000) was enacted. SB 2136 requires the Advisory Committee to recommend standards for a uniform medical quality audit system, citing the following findings:

1) Multiple medical quality audits of health care providers, as many as 25 for some physician offices, increase costs for health care providers and health plans, and thus ultimately increase costs for purchasers and consumers, and result in the direction of limited health care resources to administrative costs instead of to patient care;

2) Streamlining the multiple medical quality audits required by health care service plans and insurers is vital to increasing the resources directed to patient care; and,

3) Few legislative proposals affecting health care services have the potential of benefiting all of the affected parties, including health plans, health care providers, purchasers, and consumers, through a reduction in administrative costs without negatively affecting patient care.

[10] The regulation of health care service plans was transferred from the Department of Corporations to the newly-created Department of Managed Health Care July 1, 2000.

The Quality and Performance Measurement Subcommittee was charged with the responsibility to develop recommendations for a uniform medical quality audit system and to bring these recommendations to the full Advisory Committee.

Discussion

At the Quality and Performance Measurement Subcommittee's May 15, 2001 meeting, the Subcommittee heard presentations from stakeholders and comments from the public regarding issues that the Subcommittee should consider in making its recommendations (see Appendix 4). Work has continued on this project, most recently at the Subcommittee's July 25, 2001 and October 3, 2001 meetings. While the Subcommittee's work has not yet been completed, commonalities and areas that require further consideration are described below.

- The basic elements of a quality audit system should include the following[11]:

  - ✓ A set of quality standards approved, monitored and continually updated by the Department;

  - ✓ An independent auditing process that allows a single periodic audit of providers to satisfy various obligations of plans to monitor quality performance with respect to a particular individual or group of physicians; and,

  - ✓ Publication of such valid and relevant comparative quality information as may result from the quality audit system.

- There is a need for interagency cooperation to ensure consistency in rules. There is a commonality between the types of information that the Department, the Department of Health Services, CMS and NCQA review.[12]

- A single provider audit, based upon a uniform core set of quality standards, would appreciably ameliorate the problem of duplicative audits. The 1380.1 Working Group's standards should be the starting point for standards development, with standards updated to include additional patient protections from legislative and regulatory changes since the Working Group's December 1999 Report. For areas for which the 1380.1 Working Group did not develop standards, the Department should consult with interested parties to develop draft standards.[13]

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[11] *Uniform Medical Quality Audit System,* California Medical Association memorandum to Quality and Performance Measurement Subcommittee.

[12] *Medi-Cal Audit Crosswalk, January 2001,* prepared for the Medi-Cal Policy Institute by Kristine Thurston, Meshell Hicks, Lana Cotner, and Steve Friedmand of NCQA.

[13] *Reducing Duplicative Provider Audits, A Strategic Blue Print for Action, The Working Group's Section 1380.1 Report, December 1999*, Executive Summary, and Exhibits 4, 5 and 6; and, *Provider Group Audits,* handout of presentation by Dr. Brad Gilbert.

- Consideration should be given to including HEDIS® performance measures in core quality standards for provider groups, as these are commonly accepted by health plans, providers, and purchasers. Consideration may also be given to including CAHPS® measures at the provider group level. However, the Subcommittee needs to address how much, if any, of the audit is a scoring audit and how much of the audit is an educational opportunity to correct problems.

- There is a need for 'guidelines' for focused audits when health plans or medical groups must follow up with quality related issues, grievances, or patterns of denials.

- The goal of the uniform quality audit system is to improve quality as well as lessen the burden on medical groups and it should provide opportunities for meaningful quality improvement. Consideration should be given to requirements that every provider group have quality improvement mechanisms in place that are pertinent and meaningful to the scope of that practice.

- Consideration should be given to creating a Quality Advisory Body or Quality Council to ensure that core information is put together in a way that can be assessed and to update standards as necessary on a regular basis.

- There should be a periodic program assessment of the uniform medical quality audit system.

Timeframe

SB 2136 requires the Advisory Committee to recommend to the Director standards for a uniform medical quality audit system, which shall include a single periodic medical quality audit. SB 2136 requires the Director to publish proposed regulations for a single uniform medical quality audit on or before January 1, 2002. It is anticipated these standards will initially address full-service health plans. The Department anticipates bringing the recommendations of the Quality and Performance Measurement Subcommittee to the full Advisory Committee at its December 5, 2001 meeting, and finalizing these upon review and comment by Advisory Committee members. The Advisory Committee may subsequently consider recommending standards specific to specialized health care plans.

III. The Director Should Explore e-Health Strategies to Promote Patient Access and Quality Improvement.

Many e-Health strategies hold the promise of significant multi-dimensional changes for the managed health care system. One e-Health strategy that is relevant to patient access and quality improvement is the electronic medical record. However, there are important considerations such as patient privacy and whether there is a need for uniform requirements as medical groups and physicians participate with multiple health plans.

Background

In addition to holding the promise for improving communication between members of the health care team, electronic medical records may enhance patients' access to their own medical records and enable patients to communicate with their physicians.[14] The electronic medical record will also allow for aggregation of information at the physician or group practice level, and by allowing comparability of patient data, can also be used for conducting health care effectiveness studies and establishing clinical practice guidelines for evidence-based care. Further, there may be applications such as telemedicine and teleradiology, which could improve access for people in rural areas as well as decrease costs. Lastly, electronic medical and Internet technologies have the potential to reduce medical errors. However, there are concerns that electronic medical records represent a threat to maintaining the privacy of patient-identifiable medical records, as an electronic medical record can be accessed by anyone with access to the data system and relevant passwords. In addition, there are questions about how such electronic medical record systems can be funded.

Other relevant e-Health topics include such issues as access to Internet-based health information and quality performance information, Internet-based enrollment, simplification of billing and claims processing, physician referral and authorization systems, enrollee eligibility verification, and laboratory and pharmacy applications.

Discussion

The Department held an e-Health Summit as part of the Advisory Committee's July 10, 2001 meeting to explore the current state of e-Health technology in California HMOs and determine if there is a role for the Department in promoting better use of Internet technology for HMO consumers. The Department heard from leaders in the HMO industry, consumers, e-Health leaders and others about the state of e-Health in California HMOs, the potential benefits of e-Health, the challenges we face and what, if any, role the Department can play in promoting e-Health deployment.

[14] Tsai, Christopher C., BA and Starren, Justin, M.D., Ph.D., *Patient Participation in Electronic Medical Records,* Journal of the American Medical Association, Vol. 295, p. 1765, April 4, 2001.

The e-Health Summit provided an overview introduction of the current state of e-Health in California HMOs. Speakers provided the audience with information about the promise of e-Health and discussion addressed e-Health topics such as on-line patient records, prevention, and automatic appointment systems. In addition, the Summit addressed the challenges of e-Health issues including patient privacy issues, and digital divide issues such as how e-Health can meet the challenge of culturally and linguistically diverse populations. Finally, the e-Health Summit focused on how e-Health is being deployed. The Advisory Committee agreed the Department should play a role in promoting e-Health strategies.

Timeframe

The Department conducted its e-Health Summit at the Advisory Committee's July 10, 2001. The Health Care Education and Access Subcommittee is going to continue to frame issues and make recommendations regarding the potential role of the Department concerning utilization of e-Health technologies.

IV. The Director Should Assure that Health Plans Provide Enrollees with Fair and Timely Complaint Resolution Procedures Including the Opportunity to Appeal Denials of Health Care Services.

Health plans are required to maintain grievance systems for a variety of reasons, including to ensure that enrollees have a means to seek assistance in receiving health care services and to appeal denials of requests for health care services. Health plans must assure that enrollee grievances are handled in a manner that is timely and ensures fair consideration of grievance issues. When enrollees are unable to resolve grievances with their health plans, they may file grievances with the Department's HMO Help Center. Through identification of common types of grievance problems found in the course of reviewing complaints filed at the HMO Help Center, and with recent legislation which reduces the amount of time for both health plans and the Department to resolve enrollee grievances, the Department has issued draft regulations, which are currently at the Office of Administrative Law for review, designed to ensure a fair and timely grievance process. Adoption and implementation of these regulations will improve health plans' grievances procedures, and, therefore, improve the ability of enrollees to obtain medically necessary health care services.

Background

Under the Knox-Keene Act, health plans are required to establish and maintain a grievance system to resolve enrollee complaints against plans regarding health care services. The Knox-Keene Act also allows an enrollee to file an unresolved grievance with the Department for review and establishes a process for the Department to resolve a grievance. Senate Bill 189 (Chapter 542, Statutes of 1999), among other things, amended the Knox-Keene Act to reduce the period of time, from 60 to 30 days, in which plans and the Department have to review and resolve enrollee complaints; allows enrollees to seek the Department's review of unresolved grievances after 30 days (instead of 60 days); and requires plans to act on emergency grievances, including those involving severe pain, within three days of receipt of the grievance (instead of five days).

Assembly Bill 1663 (Chapter 979, Statutes of 1996), and Senate Bill 189 (Chapter 542, Statutes of 1999), required health plans to provide an external, independent review process to examine plan coverage decisions regarding experimental or investigative therapies for enrollees with a life-threatening or seriously debilitating condition. Assembly Bill 55 (Chapter 533, Statutes of 1999), gave the Department the responsibility to establish an independent medical review system for experimental and investigational therapies and when plans have denied, modified, or delayed health care services based on a finding that the services are not medically necessary.

The Department has already taken actions to improve systemic issues that improve the resolution process for enrollee grievances filed at the Department. The April 1999 California State Auditor Report[15] found that the Department of Corporations, which preceded the Department of Managed Health Care as California's health plan regulatory agency, took excessive time to resolve enrollee complaints filed with the State. The April 1999 Auditor Report found more than half the complaints open as of December 31, 1998 had not been resolved within the then required 60 day time frame. At

[15] *Department of Corporations' Regulation of Health Care Plans: Despite Recent Budget Increases, Improvements in Consumer Protection Are Limited,* Report of the California State Auditor, Bureau of State Audits, April 1999.

the time of the publication of this report, even with the more stringent 30-day resolution period, the Department has completely eliminated the backlog of open complaints.

With regard to health plans' internal grievance systems, through reviewing complaints filed by enrollees with the Department's HMO Help Center, as well as through the Department's on-site medical survey review of plans' grievance systems, the Department has identified the following types of problems that may occur with plans' grievance resolution processes:

- **Lack of consistent definitions of complaints, grievances, and appeals of denials of care has resulted in enrollees not being afforded access to plans' grievance processes**

  The Knox-Keene Act requires specific grievance resolution timeframes and notices be sent to enrollees filing grievances. However, in the past, some health plans may have considered complaints received by telephone to be 'informal' and, notwithstanding the nature of these complaints, enrollees did not always receive notice that they could file an unresolved complaint with the Department. In addition, enrollee grievances or appeals concerning denials of care may occur initially at the medical group level, but, unless these are appropriately categorized as grievances, enrollees may not be afforded consideration of appeals within required timeframes, or notice that they may appeal denials to the Department.

- **Excessive time for plans to resolve enrollee grievances**

  Some plans have had multi-level grievance processes that have resulted in significant total time for an enrollee to exhaust these plans' internal grievance procedures. Further, for some plans with a multi-level grievance process, the initial level(s) may have been less thorough than subsequent appeal levels, but some enrollees, with significant grievance issues, drop out of the grievance process after the initial stage(s).

- **Lack of necessary information in grievance records**

  In order for a grievance to be fairly considered, grievance reviewers require sufficient information to make an independent and fair assessment, which, for a denial of care or claims denial decision, includes relevant information concerning the enrollee's medical condition and information regarding the specific nature of the medical services requested or received. Further, the plan reviewer must have the ability to review the specific clinical issues presented (added by Senate Bill 1832 Chapter 614, Statutes of 1994). Medical records information has been requested by the Department for grievances filed with the HMO Help Center, and yet such information has not always been readily available. This has prevented the Department from completing its own review in a timely manner, and has raised questions about the integrity of plans' grievance procedures, in those cases.

- **Lack of plan personnel available to handle an urgent complaint**

  The Department's HMO Help Center operates 24 hours, seven days a week. In order for the Department to assist enrollees with urgent complaints, the Department must be able to reach health plans' designated contact persons after normal business hours. There has been one notable occasion when the Department's nurse consultant was unable to reach a responsible official at a plan on a timely basis concerning an urgent complaint.

Discussion

The Department issued emergency regulations to require that plans include procedures for the expedited review of grievances, including a system to provide for receipt of Department contacts regarding urgent grievances 24 hours a day, seven days a week. Additional regulations regarding plans' grievances processes and the independent review system at the time of the publication of this report are pending review in the rule-making process. These grievance regulations include the following provisions:

- ✓ Grievances are defined to include any written or oral expression of dissatisfaction and include any complaint, dispute, and request for reconsideration or appeal made by an enrollee or the enrollee's representative to a health care service plan or entity with delegated or contracted authority to resolve grievances on behalf of the plan. Where the plan is unable to distinguish between grievances and inquiries, they shall be considered grievances.

- ✓ A written acknowledgement must be sent for any grievance received by telephone or mail, except for grievances resolved within one business day, unless the grievance concerns a coverage dispute, or disputed health care services involving medical necessity or experimental or investigational treatment in which case a written acknowledgement must be sent regardless how quickly it is resolved.

- ✓ 'Resolved' is defined to mean that the grievance has reached a final conclusion and that there are no pending appeals within the plan's internal grievance system, including entities with contracted or delegated authority.

- ✓ All levels of appeal must be completed within 30 days of the health plan's receipt of the grievance.

- ✓ Plans must address the linguistic and cultural needs of their enrollee population as well as the needs of enrollees with disabilities.

- ✓ For grievances involving delay, modification or denial of services based on a finding in whole or in part that the service is not medically necessary; plans must include in the written decision the reasons for this determination. The plan's response must state that the subscriber or enrollee may request a copy of the criteria, clinical guidelines or medical policies used and information on how these may be obtained. The plan's response must also advise the enrollee that the determination

may be brought to the Department's independent medical review system for consideration, and include an application and instructions for independent medical review, as well as an envelope addressed to the Department's HMO Help Center.

- ✓ When an enrollee submits a grievance to the Department's HMO Help Center and the Department notifies the plan, the plan must submit the following information within five calendar days: the plan's response to the issues raised by the enrollee with the Department; a copy of the plan's response to the enrollee's grievance filed with the plan; a complete and legible copy of any and all medical records related to the grievance; a copy of the cover page and relevant portions of the enrollee's evidence of coverage; any other relevant information the plan used to reach its decision; any other information the plan believes is relevant to the resolution of the grievance; and, if the plan did not use medical records or rely upon any information other than the evidence of coverage to make its decision, the plan shall so state in its response to the Department.

- ✓ Procedures are clarified for expedited review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, or potential loss of life, limb, or major bodily function.

- ✓ Independent medical review system procedures are clarified for denial of coverage of an experimental or investigational therapy, and for cases of medical necessity.

- ✓ Plans are required to track grievances, and report grievances pending beyond 30 days, in a specified consistent manner.

Timeframe

The formal rule-making package of grievance and independent medical review regulations has been finalized and has been sent to the Office of Administrative Law. The Regulatory Implementation and Structure Subcommittee discussed these draft regulations, revised from an earlier version, extensively at its September 25, 2001 meeting. The public also had an opportunity to make significant comments on issues contained in the draft.

V. The Director Should Consider a Broad Range of Options to Ensure Consistent Consumer Protections for Persons With Health Care Coverage.

Currently, HMOs are regulated by the Department under the Knox-Keene Act while Preferred Provider Organizations (PPOs), for the most part, are regulated by the California Department of Insurance (CDI) under the Insurance Code.[16] Many HMOs also have point-of-service products so that the distinctions between HMOs and PPOs are blurred. This situation frequently leads to confusion by consumers about where to seek assistance when they are experiencing problems with their health plan (or health insurer), and insofar as the Department and CDI complaint functions differ, enrollees/insureds are provided a different level of assistance when they experience problems. In addition, while some of the same consumer protection laws apply to entities regulated by either the Knox-Keene Act or the Insurance Code, there are some key differences which impact quality of care.

Background

Assembly Bill 78 (Chapter 525, Statutes of 1999) requires that the Director, in conjunction with the Advisory Committee, undertake a study to consider the feasibility and benefit of consolidating into the Department the regulation of other health insurers providing insurance through indemnity, PPO and exclusive provider organization ("EPO")[17] products, as well as through other managed care products regulated by CDI. The results of the study along with the recommendations of the Director will be incorporated into a report to the Governor and the Legislature no later than December 31, 2001.

The Regulatory Implementation and Structure Subcommittee of the Advisory Committee has been exploring the impact of these issues on consumers (see Appendix 5). Presentations and information provided to the Regulatory Implementation and Structure Subcommittee have identified the following key differences between HMO and PPO regulation:

1) PPOs reimburse for services after services have been provided, whereas the prevailing practice is for HMOs to arrange and provide services and pay for services on a pre-paid, in-advance basis.

2) Provider Arrangements: PPOs contract with or lease networks of providers who have agreed to accept specified reimbursement rates for services. HMOs usually limit covered services to their contracted provider network. The networks for PPOs tend to be larger than HMO networks and are not limited to service areas.[18] A key difference between PPO networks and HMO arrangements with Independent Physician Associations ("IPA")[19] is that an "IPA" can be at risk whereas a PPO network cannot.

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[16] Two full service PPOs, Blue Shield of California dba California Physicians' Service and Blue Cross of California, as well as an additional number of specialized PPOs, are regulated by the Department under the Knox-Keene Act.

[17] An Exclusive Provider Organization (EPO) is a health care benefit arrangement similar to a Preferred Provider Organization in administration, structure and operation, but which does not cover out-of-network care.

[18] *Some Important Differences Between PPO's and HMO's*, Association of California Life & Health Insurance Companies

[19] An IPA is an organization of independent physicians established as a separate legal entity for contracting with managed care plans for the provision of professional medical services.

3) Quality Oversight: A key difference between the Knox-Keene Act and the Insurance Code concerns quality assurance requirements. HMOs are required to establish procedures for continuously reviewing quality of care [Health & Safety Code Section 1370]. Insurers are not required to establish their own direct quality of care review.

   Because HMOs control from whom members receive care, HMOs are subject to stricter quality controls than PPOs. The Department conducts on-site medical surveys and ensures the adequacy of networks within service areas. CDI does not conduct medical surveys. The scope of a Department medical survey includes a review of the following:

   - ✓ Utilization Management, including procedures for pre-authorization, and review of medical necessity and continuity of care, compliance with pertinent legislation about timing of decisions and who makes decisions, and the plan's processes for identifying over- and under-utilization;
   - ✓ Quality Management, including review process and results of plan actions to improve health care services;
   - ✓ Access and availability, including review of the plan's provider network by type and number of providers and availability and timeliness of services; and,
   - ✓ Grievance System, including whether the plan acts promptly to investigate and resolve grievances and integrates grievance information into its quality management process.

4) Consumer Complaints: Both the Department and CDI have 'hot lines' for consumer complaints. The Department has a more extensive hot line operating 24 hours per day, seven days per week ("24/7") because the Department deals with some cases in which services have not yet been provided. CDI generally only deals with claims complaints after services have been provided, so CDI does not operate a 24/7 hot line. The HMO Help Center's nurses work on urgent cases, and also work on quality of care issues with participation by the Department's Medical Advisor; the HMO Help Center's staff also includes nine attorneys who work on complaint issues as needed. By contrast, CDI's hot line has no clinical personnel because they are not dealing with quality of care issues; they only look at contract issues, that is, whether the company is complying with the provisions of an insurance policy.

5) Benefit Design: While there are some mandated benefits under CDI, enrollees in health plans regulated under the Department are assured of a set of basic services since Knox-Keene requires a basic benefit package.

Discussion

The Regulatory Implementation and Structure Subcommittee determined that it would be in the best interest of the Department to contract with a qualified consultant to conduct the necessary studies, perform the required analysis and draft options for consideration by the Advisory Committee and the Director. At the May 9, 2001 Regulatory Implementation and Structure Subcommittee meeting, Department staff announced the selection of an academic consultant, Professor Clark Kelso of the McGeorge School of Law, who has also served briefly as appointed Acting Insurance Commissioner

for the CDI. The Department has finalized the contract with this Consultant for this purpose. The Consultant has performed the research and analysis necessary to develop options for consideration pertaining to the feasibility and desirability of transferring the jurisdiction over one or more types of health insurance from the CDI to the jurisdiction of the Department. A draft report was discussed at the Advisory Committee's October 10, 2001 meeting. The Consultant's final report will include a range of options that may be considered, based on the analyses and input from stakeholders, and analyses of the advantages and disadvantages to be expected from implementing each option.

In performing the necessary analyses, the Consultant will consider the following issues[20]:

- ✓ The relative strength and effectiveness of consumer protection rules available under the two departments;
- ✓ The advantages, and disadvantages to consumers from having a single source of governmental assistance in resolving difficulties with health insurers/plans;
- ✓ The scope and appropriateness of each department's regulation of quality of care issues;
- ✓ The regulatory scope and capability of each department regarding health care solvency issues;
- ✓ The need to treat similarly situated entities in a similar manner (i.e., to maintain a "level playing field" for health insurers/plans);
- ✓ The potential for "forum shopping" by entities that may be in a position to choose between two regulators;
- ✓ The advantages and disadvantages of, and comparative differences between, the methods used by each department to assess fees from its licensees (including any changes in revenue generation caused by a transfer of jurisdiction);
- ✓ An analysis of the administrative effect, and short and long-term costs of transferring jurisdiction between departments;
- ✓ The business impact (including impact on corporate structure and operations) on affected entities of any transfer in jurisdiction or change in regulatory scope; and,
- ✓ The need for, and consequences of, statutory revisions that may be necessary, with respect to each option, to effectuate transfer of jurisdiction or change in regulatory scope.

While the scope of this study is limited to comprehensive, commercial plans regulated by the Department and the CDI, the Advisory Committee recommends further examination of issues relating to California's regulatory framework. This includes currently unregulated entities such as provider groups.

[20] As a preliminary question, the Regulatory Implementation and Structure Subcommittee expressed concern whether, in view of the passage of Proposition 103, the Legislature could change the jurisdiction of the CDI without a vote of the people. Proposition 103 had two components, auto reform and an elected insurance commissioner; the voters voted to have an elected commissioner over all CDI activities. The Department asked Professor Kelso to address this issue. He noted at the Subcommittee's September 25, 2001 meeting that it was permissible to alter the Insurance Commissioner's jurisdiction over health insurance, and that nothing in Proposition 103 would prohibit this.

Timeframe

The Consultant delivered a draft report to the Regulatory Implementation and Structure Subcommittee on September 11, 2001. A subsequent re-draft was reviewed and discussed at the Subcommittee's September 25, 2001 meeting, and another draft was sent to the full Advisory Committee and discussed at the October 10, 2001 meeting. The final report to the Governor and Legislature is due December 31, 2001. Following consideration and discussion by the Subcommittee and Advisory Committee, the Department will work with the Consultant to complete a final report to meet the December 31, 2001 deadline.

APPENDIX 1

Members of the Advisory Committee on Managed Health Care

NAME	ORGANIZATION	APPOINTED BY
John Alksne, M.D.	University of California, San Diego School of Medicine	Governor
R. Steven Bull, D.D.S.*	Delta Dental Plan of California	Governor
Thomas Davies, Esq.	Verizon Communications	Governor
Morton Field, M.D.	Private practice, internal medicine	Governor
Alfred Forrest, M.D.	Martin Luther King/Charles R. Drew Medical Center	Governor
Jay Gellert	Health Net of California, Inc.	Governor
Jose J. Gonzalez	Latino Health Care	Governor
Diane Griffiths	Assembly Speaker Robert M. Hertzberg's office	Speaker of the Assembly
Rosetta Hassan, M.D.	Martin Luther King/Charles R. Drew Medical Center	Governor
Irene Ibarra, Esq.	Alameda Alliance for Health	Governor
Elizabeth Imholz, Esq.	Consumers Union of U.S., Inc., West Coast Regional Office	Governor
Paul Kumar	Service Employees Internal Union (SEIU) Local 250	Senate Rules Committee
Larry Levitt, M.P.P.	Henry J. Kaiser Family Foundation	Speaker of the Assembly
Michele Melden, Esq.	San Fernando Valley Neighborhood Legal Services	Speaker of the Assembly
Stuart Needleman, O.D.	Vision Plan of America	Governor
Pratibha Patel, M.D.	Harriman Jones Medical Group	Governor
Thomas Porter	State Director, AARP	Senate Rules Committee
Naomi Strom, R.N.	University of California, San Francisco/Fresno Medical Education Program	Governor
Steven Thompson	California Medical Association	Senate Rules Committee
Art Torres, Esq.	Former California State Senator; California Democratic Party	Governor
Susan Urbanski, M.N., R.N.	CIGNA Behavioral Health of California	Governor

* Dr. Bull served on the Advisory Committee until May 2001.

Meeting Dates of the Advisory Committee on Managed Health Care and Subcommittees

Advisory Committee on Managed Health Care

October 24, 2000
January 22, 2001
April 11, 2001
July 10, 2001
October 10, 2001

Health Care Education and Access Subcommittee

December 5, 2000
February 6, 2001
March 23, 2001
May 1, 2001
June 13, 2001

Quality and Performance Measurement Subcommittee

December 7, 2000
January 30, 2001
March 21, 2001
May 15, 2001
July 25, 2001
October 3, 2001

Regulatory Implementation and Structure Subcommittee

November 29, 2000
December 15, 2000
February 9, 2001
April 2, 2001
May 9, 2001
July 18, 2001
September 18, 2001
September 25, 2001

APPENDIX 2

Set forth below are the speakers and materials considered by the Quality and Performance Measurement Subcommittee for its recommendations for the (Year 2) Report Card on Comparative Health Plan Performance.

Panels and Speakers

December 7, 2000 Quality and Performance Measurement Subcommittee Meeting:

Status of Report Cards in California

Speakers:

- Peter Lee, President, Pacific Business Group on Health
- David Hopkins, Director of Health Information Improvement, Pacific Business Group on Health
- Nancy Welch, Chief, Health Program Development Division, CalPERS
- Lisa Tanaka, Manager, Contracts Section, Health Benefit Services Division, CalPERS

Public Comments:

- Beth Capell, Ph.D., Health Access
- Mike Ralston, M.D., Permanente Medical Group
- David Grant, Director, Medi-Cal Quality Project
- Jennifer Chen, Community Health Council Los Angeles

Performance Measurement and Reporting

Speakers:

- Laura Aiuppa, Director, Information Products, National Committee on Quality Assurance
- Jennifer Eames, California Health Care Foundation

Public Comments:

- Earl Lui, Senior Attorney, Consumers Union

January 22, 2001 Advisory Committee Meeting:

Presentation: How to Design Health Plan Report Cards

Speaker:

- Elizabeth A. McGlynn, Ph.D., Director, Center for Research on Quality Health Care

January 30, 2001 Quality and Performance Measurement Subcommittee Meeting:

Expectations about the Report Card from the Health Plan Community

Speakers:

- Michael J. Belman, M.D., M.P.H., Staff Vice President, Medical Director of Quality Management, Blue Cross of California
- Gifford Boyce-Smith, M.D., Director of Quality and Network Management, Blue Shield of California
- Joel Hyatt, M.D., Assistant Associate Medical Director/Clinical Services, Southern California Permanente Medical Group, Kaiser Permanente Medical Care Program
- John E. Schneider, Ph.D., Director of Research, California Association of Health Plans

Public Comments:

- Ivan Berger, D.D.S., Chief Dental Officer, DentiCare of California, Inc.
- Leanne Gassaway, Project Manager, Government Relations, PacifiCare of California
- Ray Morales, M.D., Tower Health

Expectations about the Report Card from the Provider Community

Speakers:

- Robert Margolis, M.D., C.E.O., HealthCare Partners
- Ronald P. Bangasser, M.D., Medical Director, Beaver Medical Group
- Janet M. Richmond, Esq., Vice President, Legal Counsel, California Healthcare Association

Expectations about the Report Card from the Purchasing Community and Consumers

Speakers:

- J. Bridget Sheehan-Watanabe, J.D., Health Policy Analyst, Center for Health Care Rights
- Barbara Decker, Manager of Benefits for Edison International
- Thomas G. Moore, Jr., Consultant, Health Policies and Programs, Service Employees International Union (SEIU)

Background Materials for October 24, 2000 Advisory Committee Meeting

- *Health Plan Quality and Performance Report*, California Public Employees' Retirement System
- *California Consumers Talk About Health Care Quality*, *Findings from Focus Group Discussions*, California HealthCare Foundation
- *Health Care Quality? What You Need to Know*, HealthScope: The Consumer Guide to Choosing Health Plans, Hospitals and Medical Groups

- *2000, Report on Quality, California Health Plan Performance Results*, California Cooperative Healthcare Reporting Initiative
- *Improving Health Care Quality, Opportunities for Intervention by Consumer Groups,* Center for Health Care Rights
- *The State of Managed Care Quality 1999*, National Committee for Quality Assurance
- *New Jersey Managed Health Care Plans, Compare Your Choices*
- *Comparing the Quality of Maryland HMOs, A Guide for Consumers*

Background Materials for December 7, 2000 Quality and Performance Measurement Subcommittee Meeting

- Uniform Medical Quality Audit System and Standards, Senate Bill 2136, Analysis
- Knox-Keene Health Plans Included in California Report Cards (chart)
- *Health Plan Quality and Performance Report*, California Public Employees' Retirement System
- *Health Care Quality? What You Need to Know*, HealthScope: The Consumer Guide to Choosing Health Plans, Hospitals and Medical Groups
- *The Quality Initiative, The Case for Quality in Health Care*, California HealthCare Foundation
- Elements Included in California and Other State Report Cards (chart)
- *2000, New Jersey HMO Performance Report*
- *Comparing the Quality of Maryland HMOs: A Guide for Consumers*
- *New York State HMO Report Card*
- *Comparing Texas HMOs 2000*
- *New Mexico Consumer Guide: Choosing a Quality Managed Care Plan*
- *Utah Medicaid HMO Performance Report: Compare Your Choices*
- *The Minnesota 1997 HMO Profile*
- *Field Testing to Improve Information Materials for Consumers, a Do-It-Yourself Guide*, Jeanne McGee, Ph.D.

Background Materials for January 30, 2001 Quality and Performance Measurement Subcommittee Meeting

- Uniform Medical Quality Audit System and Standards, Senate Bill 2136, Analysis
- Meeting notes from December 7, 2000 Quality and Performance Measurement Subcommittee meeting
- Summary pages of background material for December 7, 2000 Quality and Performance Measurement Subcommittee (see above)
- *National Survey on Americans as Health Care Consumers: An Update on the Role of Quality Information*, the Kaiser Family Foundation and the Agency for Health Care Research

Handouts from Panelists and Public Participants at December 7, 2000 Quality and Performance Measurement Subcommittee Meeting

- *Health Plan Quality and Performance Report*, California Public Employees' Retirement System (most recent report and report from 1997)
- *2000, Report on Quality, California Health Plan Performance Results*, California Cooperative Healthcare Reporting Initiative
- *Los Angeles County 1999 Consumer Report Card*, Medi-Cal Managed Care
- *When What's Ailing You Isn't Only Your Health*, J. Bridget Sheehan-Watanabe, Health Rights Hotline Report on Consumers' Experiences in El Dorado, Placer, Sacramento and Yolo Counties, August 2000
- *The Case for Quality in Health Care, Medical Errors, Underuse and Overuse of Medical Services, Variations in Medical Practice, Improving Quality through Patient Participation in Health Care Decision Making,* multiple publications from The Quality Initiative, California HealthCare Foundation
- *California Consumers Talk About Health Care Quality, Findings from Focus Group Discussions*, California HealthCare Foundation
- *Health Care Quality in California, a Primer*, California HealthCare Foundation
- *Geography is Destiny, California Variations in Medical Practice* as reported by The Dartmouth Atlas of Health Care 1999, California HealthCare Foundation

Handout from Speaker at January 22, 2001 Advisory Committee Meeting

- *How to Design Health Plan Report Cards*, Elizabeth A. McGlynn, Ph.D., Director, Center for Research on Quality in Health Care

Handouts from Speakers and Public Participants at January 30, 2001 Quality and Performance Measurement Subcommittee Meeting

- *Health Plan Expectations About Report Cards*, Joel D. Hyatt, M.D.
- *Brief Overview of Health Plan Quality Reporting Systems,* John E. Schneider, Ph.D.
- *Consumer Advocates' Perspectives on Department HMO Report Cards*, J. Bridget Sheehan-Watanabe
- *PacifiCare of California Fall 2000, Quality Index*

APPENDIX 3

Set forth below are the speakers and materials presented to the Health Care Education and Access Subcommittee concerning the preventive health care initiative.

December 5, 2000 Health Care Education and Access Subcommittee Meeting:

State of Prevention in California

Speaker:

- Steven Fisher, Deputy Director for Communications and Planning, Department of Managed Health Care

January 22, 2001 Advisory Committee Meeting:

Update and discussion of Health Care Education and Access Subcommittee

Speaker:

- Patricia Felton, M.A., California Center for Health Improvement

February 6, 2001 Health Care Education and Access Subcommittee Meeting:

The State of Health Prevention in California

Speakers:

- Sara McMenamin, M.P.H., Director of Research, Center for Health and Public Policy Studies, University of California, Berkeley
- Margaret Taylor, M.A., M.F.C.C., Director, San Mateo County Health Services Agency

March 23, 2001 Health Care Education and Access Subcommittee Meeting:

Lessons Learned: A National Perspective on Improving the Provision of Preventive Services

Speakers:

- Karen A. Bodenhorn, R.N., M.P.H., President and CEO, California Center for Health Improvement
- Ashley Coffield, M.P.A., President, Partnership for Prevention
- Jonathan E. Fielding, M.D., M.P.H., M.B.A., Director of Public Health and Health Officer, Los Angeles County Department of Health Services

- Brad Myers, Senior Communications Specialist, Community Guide Branch, Centers for Disease Control and Prevention

Public Comments:

- Robert Weiss

May 1, 2001 Health Care Education and Access Subcommittee Meeting:

Consumer Education and Access to Health Care Services Targeting Minority Populations

Speakers:

- Laurie Primavera, R.N., F.N.P., M.S.N., C.E.O., Sequoia Health Care Foundation, Fresno
- Sandra Belman, M.P.H., C.D.E., Health Education Director, Sequoia Health Care Foundation, Fresno
- Thomas Mahoney, M.D., M.P.H., Sequoia Health Care Foundation, Fresno
- Vickie Krenz, Ph.D., M.S.P.H., Department of Health Science, California State University, Fresno

HMO Update on Prevention Efforts

Speakers:

- Scott Gee, M.D., Regional Associate Director for Preventive Medicine, Regional Health Education, The Permanente Medical Group, Inc., Northern California
- Michael J. Belman, M.D., M.P.H., Staff Vice President, Medical Director of Quality Management, Blue Cross of California
- Dan Shydler, Regional Director of State Sponsored Programs**,** Fresno Central Region, Blue Cross of California
- Rachna Panolya, Blue Cross of California Cultural and Linguistics Program

Policy Issues Regarding Access to Health Care for Minority Communities

Speakers:

- McKinley Jones, Ph.D., California Black Health Network
- Andrew Alvarado, M.S.W., Ed.D., Professor, Department of Social Work Education College of Health and Human Services California State University, Fresno
- Chi Kue, Executive Director, Hmong American Women Association

June 13, 2001 Health Care Education and Access Subcommittee Meeting:

Prevention Report Discussion With the Department's Medical Advisor

Speaker:

- Antonio Linares, M.D., Medical Advisor to the Director, Department of Managed Health Care

Prevention Report: Discussion with the Patient Advocate

Speaker:

- Angela Mora, Patient Advocate[21]

Prevention Report Discussion Steps with Department Staff

Speaker:

- Steven Fisher, Deputy Director for Communications and Planning, Department of Managed Health Care

Background Materials for December 5, 2000 Health Care Education and Access Subcommittee Meeting

- *The State of Prevention in California*, California Center for Health Improvement
- *Promoting Prevention in Children's Health Coverage*, California Center for Health Improvement
- *Changing the Healthcare Landscape, Baby Boomers Focus on Education, Prevention as They Approach Menopause*, Deborah Kelch, M.P.P.A., California Center for Health Improvement

[21] Dr. Martin Gallegos has subsequently succeeded Ms. Mora as the Patient Advocate.

Background Materials for March 23, 2001 Health Care Education and Access Subcommittee Meeting

- *Introducing the Guide to Community Preventive Services: Methods, First Recommendations and Expert Commentary,* American Journal of Preventive Medicine, January 2000
- *Second Edition of the Guide to Clinical Preventive Services, Report of the U.S. Preventive Services Task Force, 1996*[22]
- *The Guide to Community Preventive Services: Tobacco Use Prevention and Control, Reviews, Recommendations, and Expert Commentary, American Journal of Preventive Medicine, February* 2001[23]
- *The Guide to Community Preventive Services: Update on Development and Dissemination Activities*, Stephanie Zaza and Jeri D. Pickett, Journal of Public Health Management and Practice, 7(1), 92-94.

- *Vaccine-Preventable Diseases: Improving Vaccination Coverage in Children, Adolescents, and Adults, A Report on Recommendations of the Task Force on Community Preventive Services,* Morbidity and Mortality Weekly Report, June 18, 1999, Vol. 48, No. RR-8.
- *Strategies For Reducing Exposure to Environmental Tobacco Smoke, Increasing Tobacco-Use Cessation, and Reducing Initiation in Communities and Health-Care Systems: A Report on Recommendations of the Task Force on Community Preventive Services,* Morbidity and Mortality Weekly Report, November 10, 2000, Vol. 49, No. RR-12.

Background Material for June 13, 2001 Health Care Education and Access Subcommittee Meeting

- *Draft Outline, Department of Managed Health Care Prevention Report*

Handout from Speaker at February 6, 2001 Health Care Education and Access Subcommittee Meeting

- *Prevention in Managed Care*, handout of presentation by Sara McMenamin, M.P.H.

Handout from Speaker at March 23, 2001 Health Care Education and Access Subcommittee Meeting

- *Priorities Among Recommended Clinical Preventive Services,* one page handout from Ashley Coffield, M.P.A.

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[22] *Second Edition of the Guide to Clinical Preventive Services,* Report of the U.S. Preventive Services Task Force[22], 1996, may be accessed on-line at http://odphp.osophs.dhhs.gov/pubs/guidecps. A printed copy of this publication may also be ordered from the Agency for Healthcare Research and Quality ("AHRQ"). AHRQ's web-site is http://www.ahrq.gov.

[23] *The Guide to Community Preventive Services* is being released topic by topic. For more information and to view individual chapters as they become available, see www.thecommunityguide.org.

Handouts from Speakers at May 1, 2001 Health Care Education and Access Subcommittee Meeting

- *Preventive Health in Managed Care,* handout of presentation by Michael J. Belman, M.D., M.P.H.
- *Kaiser Permanente Update on Prevention Efforts,* handout of presentation by Scott Gee, M.D.
- *Prevention Panel,* handout by Scott Gee, M.D.
- *Cultural Competency Makes a Difference: Access to Health Care Services Targeting Minority Populations,* handout of presentation by Daniel Shydler and Rachna Pandya
- *Clinical Practice Guidelines, Prevention and Health Promotion Summary,* Kaiser Permanente, revised 2000.
- *Kaiser Permanente Healthphone*
- *Preventive Health Prompt,* Kaiser Permanente
- *Bright Systems, A total Quality Management Project to Improve Children's Health,* Kaiser Permanente

APPENDIX 4

Set forth below are the speakers and materials presented to the Quality and Performance Measurement Subcommittee concerning the uniform medical quality audit system.

May 15, 2001 Quality and Performance Measurement Subcommittee Meeting:

Lessons Learned from *The Working Group's Section 1380.1 Report*

Speakers:

- Brad Gilbert, M.D., Medical Director, Inland Empire Health Plan
- Robert Margolis, M.D., C.E.O., HealthCare Partners

Public Comments:

- Jeff Album, Director of Public Affairs, Delta Dental
- Sandra E. Bressler, J.D., Director, Professional Standards and Quality of Care, California Medical Association ("CMA")
- Ivan Berger, D.D.S., Chief Dental Officer, DentiCare of California, Inc.

Collaborative Efforts to Streamline Physician Group Oversight

Speaker:

- Kristine Thurston, M.P.H., Director, Product Development, NCQA

Stakeholder Perspectives on SB 2136

Speakers:

- Jill Silverman, M.S.P.H., President and C.E.O., Institute for Medical Quality
- Ronald Bangasser, M.D., Medical Director, Beaver Medical Group, Redlands, and Chair, Quality Management Technical Advisory Committee, "CMA"
- Michael S. Ralston, M.D., Director of Quality Demonstration, Kaiser Permanente
- Gifford Boyce-Smith, M.D., Director of Quality and Network Management, Blue Shield of California
- Deborah Fleming, R.N., M.B.A., J.D., C.P.H.Q., Director of Quality Improvement, PacifiCare of California

Public Comments:

- Bill Lewis, California Dental Association
- Brent Barnhart, Counsel, Kaiser Foundation Health Plan, Inc.
- Sandra E. Bressler, J.D., Director, Professional Standards and Quality of Care, "CMA"

June 25, 2001 Quality and Performance Measurement Subcommittee Meeting:

Speakers:

- Linda Shelton, M.A., Assistant Vice President, Product Development and Kristine Thurston, M.P.H., Director, Product Development, "NCQA"
- Marvin Kamras, M.D., Ambulatory Care Review Committee; Jill K. Silverman, M.S.P.H., President & CEO; and Margaret Kelly, Vice President, Operations, Institute for Medical Quality
- B. Guy D'Andrea, Senior Vice President, The American Accreditation Healthcare Commission/ URAC ("URAC")
- Mark A. Crafton, M.P.A., Director, State Relations The Joint Commission on Accreditation of Healthcare Organizations ("JCAHO")
- Beth Capell, Ph.D., Health Access
- Sandra E. Bressler, J.D., Director, Professional Standards and Quality of Care, "CMA"
- Deborah Fleming, R.N., M.B.A., J.D., C.P.H.Q., Director of Quality Improvement, PacifiCare of California

Public Comments:

- Adrian Hochstadt, Director of Public Affairs, Accreditation Association for Ambulatory Health Care ("AAAHC")
- Sam Romeo Jr., M.D., Medical Director, University Affiliates Medical Group
- Michael S. Ralston, M.D., Director of Quality Demonstration, Kaiser Permanente, Northern California
- Kathy McCaffrey, Vice President, Health Care Data and Operations, California Association of Health Plans
- Kathy Dervin, M.P.H., California Department of Industrial Relations

Discussion Regarding Core Areas for the Uniform Medical Quality Audit System Standards

Speaker:

- Discussion facilitated by Thomas Davis, Subcommittee Chairman

Public Comments:

- Deborah Fleming, R.N., M.B.A., J.D., C.P.H.Q., Director of Quality Improvement, PacifiCare of California
- Beth Capell, Ph.D., Health Access
- Ivan Berger, D.D.S., Denticare
- Linda Shelton, M.A., Assistant Vice President, Product Development, "NCQA"
- Sandra E. Bressler, J.D., Director, Professional Standards and Quality of Care, "CMA"
- Joyce Weston, Department of Health Services, Medi-Cal Managed Care Division

October 3, 2001 Quality and Performance Measurement Subcommittee Meeting:

Discussion Regarding Systems Issues for Uniform Medical Quality Audits Including Criteria for Accreditation Organizations to Conduct the Uniform Medical Quality Audits

Speakers:

- Andrew Meyers, Deputy Director, Financial Standards and Solvency
- Thomas Gilevich, J.D., Counsel, Department of Managed Health Care

Public Comments:

- Beth Capell, Ph.D., Health Access
- Sandra E. Bressler, J.D., Director, Professional Standards and Quality of Care, "CMA"
- Sam Romeo Jr., M.D., Medical Director, University Affiliates Medical Group
- Deborah Fleming, R.N., M.B.A., J.D., C.P.H.Q., Director of Quality Improvement, PacifiCare of California
- Jill K. Silverman, M.S.P.H., President & CEO, Institute for Medical Quality
- Sheila Muller, Blue Shield of California

Discussion Regarding Draft Standards for the Uniform Medical Quality Audit System

Speakers:

- Andrew Meyers, Deputy Director, Financial Standards and Solvency
- Diane McCarthy, M.S.P.H., Research Specialist, Department of Managed Health Care

Public Comments:

- Beth Capell, Ph.D., Health Access
- Sandra E. Bressler, J.D., Director, Professional Standards and Quality of Care, "CMA"
- Sam Romeo Jr., M.D. Medical Director, University Affiliates Medical Group
- Deborah Fleming, R.N., M.B.A., J.D., C.P.H.Q., Director of Quality Improvement, PacifiCare of California Adrian Hochstadt, Director of Public Affairs, AAAHC
- Jill K. Silverman, M.S.P.H., President & CEO, Institute for Medical Quality
- Sheila Muller, Blue Shield of California

Background Materials for May 15, 2001 Quality and Performance Measurement Subcommittee Meeting

- *Reducing Duplicative Provider Audits, A Strategic Blue Print for Action, The Working Group's Section 1380.1 Report, December 1999*, Executive Summary, and Exhibits 4, 5 and 6.[24]
- *Medi-Cal Audit Crosswalk, January 2001,* prepared for the Medi-Cal Policy Institute by Kristine Thurston, Meshell Hicks, Lana Cotner, and Steve Friedmand of "NCQA"

Background Material for June 25, 2001 Quality and Performance Measurement Subcommittee Meeting

- *Core Quality Areas for the Uniform Medical Quality Audit System,* information prepared by Department of Managed Health Care staff

Background Materials for October 3, 2001 Quality and Performance Measurement Subcommittee Meeting

- *Criteria for Auditor Selection and Other Uniform Audit System Issues to be Considered,* information prepared by Department of Managed Health Care staff
- *Draft Standards for Core Quality Areas,* information prepared by Department of Managed Health Care staff

[24] The Section 1380.1 Working Group members included the following members representing the following organizations: Michael E. Abel, M.D., President and CEO, Brown & Toland Medical Group; David Chernof, M.D., Medical Consultant to the Department; Robert C. Davidson, M.D., California Medical Association and Department of Family and Community Medicine, University of California, Davis; Mary Fermazin, M.D., Chief, Office of Clinical Standards and Quality, Medi-Cal Managed Care Division, "DHS"; Thomas C. Geiser, Esq., Executive Vice President/General Counsel, Wellpoint Health Network Inc.; Bradley Gilbert, M.D., Medical Director, Inland Empire Health Plan; David Hopkins, Ph.D., Director of Health Information Improvement, Pacific Business Group on Health; Peter Lee, Esq., Director, Center for Health Care Rights; Antonio Legoretta, M.D., Corporate Vice President, Foundation Health Systems; Seymour Levine, M.D., Health Source Medical Group and member of the Health Care Service Plan Advisory Committee; Robert Margolis, M.D., Chief Executive Officer, HealthCare Partners; Gary Mendoza, Esq., Riordan & McKenzie, Member of the Health Care Service Plan Advisory Committee and Former Commissioner of the Department of Corporations; George Perlstein, M.D., Palo Alto Medical Foundation; Richard Rabens, M.D., M.P.H., Department of Quality and Utilization; Bruce Spurlock, M.D., Executive Vice President, California Healthcare Association; Nancy J. Welsh, M.B.A., Chief, Health Program Development Division, CalPERS, and Anita J. Ostroff, M.P.H., Esq., Chairperson to the Working Group.

Handouts from Speakers for May 15, 2001 Quality and Performance Measurement Subcommittee Meeting

- *Provider Group Audits,* handout of presentation by Dr. Brad Gilbert
- *Physician Group Oversight ("P-GO") Improvement Project,* handout of presentation by Kristine Thurston
- *Uniform Medical Quality Audit System,* California Medical Association memorandum to Quality and Performance Measurement Subcommittee

Handouts from Speakers for July 25, 2001 Quality and Performance Measurement Subcommittee

- *Provider Evaluation and "NCQA",* handout of presentation by Linda Shelton and Kristine Thurston
- *Criteria for Organizations Conducting Medical Audits,* Memorandum to the Advisory Committee on Managed Health Care and Quality and Performance Measurement Subcommittee by Jill K. Silverman
- *URAC Overview,* handout of presentation by B. Guy D'Andrea
- Conducting Quality Audits of Provider Groups and Individual Providers, handout of presentation by Mark A. Crafton
- Accreditation Association for Ambulatory Health Care, handout of presentation by Adrian Hochstadt
- *Physician Group Oversight ("P-GO") Improvement Project*, handout of presentation by Kristine Thurston

APPENDIX 5

Set forth below are the speakers and materials presented to the Regulatory Implementation and Structure Subcommittee concerning the issue of consolidating in the Department the regulation of other health insurers providing insurance through indemnity, PPOs, EPOs, and other managed health care products.

November 29, 2000 Regulatory Implementation and Structure Subcommittee Meeting:

Framework for Study on Regulation of Managed Health Care Plans

Speaker:

- Herb Schultz, Deputy Director for External Affairs, Department of Managed Health Care

Public Comments:

- Beth Capell, Health Access
- Anne Eowan, Vice President, Government Affairs/Secretary, Association of California Life & Health Insurance Companies
- Beau Carter, Integrated Healthcare Association
- Lyle Swallow, Associate General Counsel, Blue Shield of California

February 9, 2001 Regulatory Implementation and Structure Subcommittee Meeting:

Issues to be Considered in the Regulatory Framework Study

Speaker:

- Joy Higa, Deputy Director for Plan and Provider Relations, Department of Managed Health Care

Public Comments:

- Graham Wright
- Anne Eowan, Vice President, Government Affairs/Secretary, Association of California Life & Health Insurance Companies

Health Plan Panel on Regulatory Framework Study

Speakers:

- Anne Eowan, Vice President, Government Affairs/Secretary, Association of California Life & Health Insurance Companies

- Gail H. McIntosh, Assistant Vice President, Insurance Counsel, Pacific Life Insurance Company
- Lyle Swallow, Associate General Counsel, Blue Shield of California

Consumer Panel on Regulatory Framework Study

Speaker:

- Earl Lui, Senior Attorney, Consumers Union

Public Comments:

- Gail H. McIntosh, Assistant Vice President, Insurance Counsel, Pacific Life Insurance Company
- Tom Mays, Pacific Life Insurance Company
- Julie Soo, California Department of Insurance
- Lyle Swallow, Associate General Counsel, Blue Shield of California

April 2, 2001, Regulatory Implementation and Structure Subcommittee Meeting:

Handling Consumer Complaints: Panel Presentation and Subcommittee Discussion

Speakers:

- Penny Fowler, Division Chief, Complaint Response and Resolution, HMO Help Center, Department of Managed Health Care
- Keith Newman, Deputy Commissioner, Consumer Services and Market Conduct Branch, California Department of Insurance
- Shelley Rouillard, Program Director, Health Rights Hotline

Regulatory Oversight: Panel Presentation

Speakers:

- Keith Newman, Deputy Commissioner, Consumer Services and Market Conduct Branch, California Department of Insurance
- Jack Toney, Assistant Deputy Director, Office of Health Plan Oversight, Department of Managed Health Care

Public Comments:

- Anne Eowan, Vice President, Government Affairs/Secretary, Association of California Life & Health Insurance Companies

May 9, 2001 Regulatory Implementation and Structure Subcommittee Meeting:

Potential Legal Issues Concerning Transfer of, or Revision to Regulatory Jurisdiction

Speaker:

- Curtis Leavitt, Counsel, Office of Legal Services, Department of Managed Health Care

Public Comments:

- Anne Eowan, Vice President, Government Affairs/Secretary, Association of California Life & Health Insurance Companies
- Sean Tracy, Deputy Commissioner for Strategic Planning, Policy and Research, California Department of Insurance

Regulatory Framework Study Update

Speakers:

- Joy Higa, Deputy Director for Plan and Provider Relations, Department of Managed Health Care
- Clark Kelso, Professor of Law, and the Director for the Capitol Center for Government Law and Policy at the McGeorge School of Law

Public Comments:

- Anne Eowan, Vice President, Government Affairs/Secretary, Association of California Life & Health Insurance Companies
- Harvey S. Frey, M.D., Ph.D., Esq., Director, Health Administration Responsibility Project, Inc. (by letter)

Regulatory Oversight of Managed Care Entities

Speaker:

- Joyce Vermeersch, Chief, Office of Oversight Standards and Research, Department of Managed Health Care

Public Comments:

- Anne Eowan, Vice President, Government Affairs/Secretary, Association of California Life & Health Insurance Companies
- Kristine Thurston, M.P.H., Director, Product Development, "NCQA"

Regulatory Oversight in Other States

Speakers:

- David Korsh, Associate General Counsel, "URAC"
- Liza Greenberg, R.N., M.P.H., URAC Vice President, Research and Quality

Public Comments:

- Anne Eowan, Vice President, Government Affairs/Secretary, Association of California Life & Health Insurance Companies

July 18, 2001 Regulatory Implementation and Structure Subcommittee Meeting:

Regulation of HMOs and PPOs in Other States

Speakers:

- Barbara Morales Burke, Senior Deputy Commissioner, North Carolina Department of Insurance, Technical Services Group
- Edward J. Unger, CLU, Managed Care Bureau, New Jersey Department of Banking and Insurance
- Sylvia Allen-Ware, Director, Office of Managed Care, Division of Health Care Systems Analysis, New Jersey Department of Health Services
- Chanell McDevitt, Regulatory Officer, Office of Managed Care, Division of Health Care Systems Analysis, New Jersey Department of Health and Senior Services
- Nora Ann House, Managed Care Specialist and Past President, National Association of Managed Care Regulators

Regulatory Framework Study Update

Speaker:

- Clark Kelso, Professor of Law, and the Director for the Capitol Center for Government Law and Policy at the McGeorge School of Law

September 18, 2001 Regulatory Implementation and Structure Subcommittee Meeting:

Regulatory Framework Study Update

Speaker:

- Clark Kelso, Professor of Law, and the Director for the Capitol Center for Government Law and Policy at the McGeorge School of Law

Public Comment:

- Anne Eowan, Vice President, Government Affairs/Secretary, Association of California Life & Health Insurance Companies
- Sean Tracy, Deputy Commissioner, Strategic Planning, Policy and Research, California Department of Insurance
- Robert Scarlett, Blue Cross

September 25, 2001 Regulatory Implementation and Structure Subcommittee Meeting:

Overview of California HealthCare Foundation Report on Regulatory Oversight/Jurisdiction

Speakers:

- Debra L. Roth
- Deborah Reidy Kelch, M.P.P.A.

Regulatory Framework Study Update

Speaker:

- Clark Kelso, Professor of Law, and the Director for the Capitol Center for Government Law and Policy at the McGeorge School of Law

Public Comments:

- Beth Capell, Ph.D., Health Access
- Bonnie Burns, Director, Consumer Education, California HICAP Association
- Anne Eowan, Vice President, Government Affairs/Secretary, Association of California Life & Health Insurance Companies

Background Materials for February 9, 2001, Regulatory Implementation and Structure Subcommittee Meeting

- *Case Studies in Reducing Regulatory Duplication in Managed Care*, August 2000, paper by Allan Baumgarten prepared for the California HealthCare Foundation
- *Some Important Differences Between PPOs and HMOs*, prepared by Association of California Life & Health Insurance Companies
- *Statutory and Regulatory Overview of California Preferred Provider Organization ("PPO") Industry*, prepared by Association of California Life & Health Insurance Companies
- *Impacts of Regulatory Transfer of PPOs on Stakeholder Groups,* prepared by Association of California Life & Health Insurance Companies

Background Materials for April 2, 2001 Regulatory Implementation and Structure Subcommittee Meeting

- Consumer Complaint Process description from the Department's web-site
- Independent Medical Review frequently asked questions from the Department web-site
- The Department's HMO Help Center Monthly Report – February 2001
- J. Bridget Sheehan-Watanabe, *When What's Ailing You Isn't Only Your Health*, Health Rights Hotline Report on Consumers' Experiences in El Dorado, Placer, Sacramento and Yolo Counties, August 2000

Background Materials for May 9, 2001 Regulatory Implementation and Structure Subcommittee Meeting

- Draft Scope of Work, Regulatory Framework Study
- *State PPO Law Survey Findings, Section 3.0, The PPO Guide*, 1999 American Accreditation HealthCare Commission/URAC, Thomas G. Goddard, J.D., M.A.
- *Department Regulation of HMOs, 1997* information prepared by National Association of Insurance Commissioners

Background Materials for July 18, 2001 Regulatory Implementation and Structure Subcommittee Meeting

- *Detailed Overview of Managed Care Regulation in North Carolina and General Discussion of Managed Care Regulation in North Carolina*, information prepared by Barbara Morales Burke
- *Selected North Carolina Laws and Regulations Relating to Managed Care*
- *Selected New Jersey Laws and Regulations Relating to Managed Care*
- *Regulation of HMOs and PPOs in Oklahoma,* information prepared by Nora Ann House
- *Selected Oklahoma Laws Relating to Managed Care*

Background Material for September 18, 2001 Regulatory Implementation and Structure Subcommittee Meeting

- *Regulatory Jurisdiction Over Certain Health Insurance Products: The Department of Managed Health Care & The Department of Insurance,* September 11, 2001 draft report by J. Clark Kelso

Background Material for September 25, 2001 Regulatory Implementation and Structure Subcommittee Meeting

- *Regulatory Jurisdiction Over Certain Health Insurance Products: The Department of Managed Health Care & The Department of Insurance,* September 23, 2001 draft report by J. Clark Kelso

Handouts from Speakers at April 2, 2001 Regulatory Implementation and Structure Subcommittee Meeting

- Handout of background material concerning California Department of Insurance, Consumer Services and Market Conduct Branch Operations from Keith Newman, Deputy Commissioner, Consumer Services and Market Conduct Branch, California Department of Insurance
- Handout of presentation from Shelley Rouillard, Program Director, Health Rights Hotline
- Handout of presentation by Jack Toney, Assistant Deputy Director, Office of Health Plan Oversight, Department of Managed Health Care

Handouts from Speakers at May 9, 2001 Regulatory Implementation and Structure Subcommittee Meeting

- *Prop 103 Legal Research*, May 4, 2001, memorandum from Curtis Leavitt, Counsel, Office of Legal Services, Department of Managed Health Care
- *A Comparison of Consumer Protection Provisions of the Knox-Keene Health Care Service Plan Act and the California Insurance Code,* handout from Joyce Vermeersch, Chief, Office of Oversight Standards and Research, Department of Managed Health Care

Handout from Speakers at September 25, 2001 Regulatory Implementation and Structure Subcommittee Meeting

- *The Departments of Managed Health Care and Insurance: An Historical and Comparative Review*, handout of presentation by Debra L. Roth and Deborah Reidy Kelch